



Response to the OMB Performance and Management Assessment of the Health Professions Program

Overview

As part of the President's Management agenda the OMB recently released its Performance and Management Assessment of several competitive grant programs. The Health Professions programs, under which AHEC is subsumed, received a rating of ineffective. Three ratings are possible: effective, moderately effective, and ineffective. In arriving at this rating the OMB used the Program Assessment Rating Tool (PART). The PART rates programs in four areas:

- Program Purpose and Design
- Strategic Planning
- Program Management
- Program Results

Within each area are multiple criteria, which can be summarized as follows:

- What are you doing and why?
- How are you doing it?
- Are you doing it responsibly?
- What difference did it make?

The PART is a component of the Government and Performance Results Act (GPRA) of 1993, and provides direction for program improvement by identifying specific areas of deficiency. The criteria used by the PART have been thoughtfully developed and are consistent with the basics of planning and evaluation. The negative evaluation of the Health Professions programs is largely the result of using performance goals inappropriate to the programs. It is unclear exactly how these performance goals for BHP programs evolved within HRSA, but they do not fit the AHEC program goals as expressed in the authorizing legislation or the elaboration of that authorizing language in the annual application guidance materials.

The two areas of the Health Professions programs rated as most deficient by the PART were the "Program Purpose" and "Design and Program Results." Room for improvement was also noted in the "Strategic Planning" and "Program Management" areas, but these are primarily related to the internal management of the agency rather than to the performance of individual grantees.

General responses to the assessment of the health professions programs

All health professions programs are lumped together for the assessment. In assessing the health professions programs approximately 40 individual programs were lumped together. Some of the negative scores stem from the fact that Congress created these programs at different times and for different purposes. These programs need to be evaluated according to the original purpose of the individual program, as well as current overall agency goals.

Key performance measures are beyond the scope of the programs. Two of the three long-term performance measures for the health professions programs are largely influenced by factors over which the health professions programs have little control.

- The long-term measure, "Proportion of persons who have a specific source of reliable, continuing healthcare," is affected by health insurance coverage, income, geographic location (inner city or rural), and a host of other factors.

- The long-term measure, “Proportion of health professionals completing funded programs that are serving in medically underserved communities,” is a bit more in line with the expected outcomes of some of the health professions programs. It would be reasonable to expect a higher proportion of program graduates to locate initially in medically underserved communities. However, many other factors enter into a health care provider’s decision to remain in a medically underserved community, such as income, job opportunities for spouses, and the quality of education for children.

The third long-term performance measure to which the health professions programs are subject, “Proportion of health professionals completing Health Professions funded programs who are underrepresented minorities and/or from disadvantaged backgrounds,” is a reasonable measure for those Health Professions programs designed to address issues of diversity in the health care workforce.

The OMB report acknowledges that comparison of BHPr programs to other programs in the agency is difficult, but does suggest that the Community Health Center and National Health Service Corps programs are more successful. However, in contrast to the Health Professions programs, the three key long-term performance measures to which the CHC and NHSC programs are subjected remain well within the scope of these two programs:

Community Health Centers:

- Rate of low weight births among health center patients
- Number in millions of those served by health centers who are below 200% of poverty and the national percentage of all people below 200% of poverty served by the program
- Number of new and expanded health center sites and millions of additional people served

National Health Service Corps:

- Patients served through the placement and retention of NHSC clinicians
- Patients served through NHSC placements and retention, as well as other sources
- Average Health Professional Shortage Area (HPSA) score of areas receiving NHSC clinicians

The CHC and NHSC programs provide direct patient care services in underserved areas. AHECs and the other Health Professions programs, on the other hand, provide educational services and resources to both training programs and communities primarily in order to influence the training of future providers and improve the practice environment of current providers in underserved areas. Global health outcomes indicators are not appropriate measures to use to evaluate their success.

AHEC-Specific Responses to BHPr program deficiencies noted in the PART

OMB rated the health professions programs (AHEC, HCOP, Burdick Interdisciplinary, Primary Care training grants, etc.) as ineffective in terms of the placement of graduates into underserved areas. OMB did not do a separate evaluation of individual Health Professions programs, although individual programs are occasionally referenced as possible exceptions to the overall negative evaluation. In the table below, the left hand column provides information on those areas of the PART for which the Health Professions programs received a negative rating, and the right hand column provides a response.

Section I: Program Purpose and Design

<p>1. Is the program purpose clear?</p>	<p>The OMB Summary document reported findings that “a clear and focused purpose is not found in the authorizing legislation, external views and program documents.” This negative rating stems from the expectation that all of the individual health professions programs should have one purpose, which may or not be appropriate.</p>
<p>3. Is the program designed to have a significant impact in addressing the interest, problem or need?</p>	<p>The PART comments on this question focus on the broad reach and multitude of goals and purposes of the Health Professions programs. OMB asserted that the national impact of the Health Professions programs on diversity, distribution, supply or quality is not known.</p> <p>The PART also comments that, for most awards, there are no matching requirements. Nevertheless, it does acknowledge that some grant activities have the effect of leveraging other funds and providing seed money for new programs. AHEC Programs, for example, do require a 1:1 cash match for federal dollars and , in practice, many AHEC programs far exceed the 1:1 match requirement.</p> <p>Health Professions programs would benefit from more consistent evaluation of individual program activities and their relationship to the underlying factors (antecedent conditions) that overall program objectives address. The development of project and program “logics” for these program activities would improve their design and effectiveness within the context of individual BHPr programs and enable better tracking of activities to outcomes.</p>

Section II: Strategic Planning

<p>5. Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?</p>	<p>The negative rating on this criterion stems from the fact that the health professions programs as a whole have not undergone an independent evaluation. However, some individual programs have been subjected to independent evaluations. For example, the AHEC Program had an external evaluation completed in August 2002.</p>
<p>6. Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?</p>	<p>The PART report criticizes the agency on failure to base a determination of the level of financial resources on what is needed to obtain the agency’s annual and long-term goals, and acknowledges that this task is made more difficult by the number of discrete grant activities and the stark differences between annual budget requests</p>

	<p>and final appropriations.</p> <p>The negative assessment in this section is based on the agency’s annual budget submission to OMB and the Congress, not on the budgeting process within each of the Health Professions programs, nor on the budget justifications and documentation of need and prior program outcomes of individual grantees.</p>
<p>Section III: Program Management</p>	
<p>1. Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?</p>	<p>This question relates primarily to program management functions within BHP. The PART report notes that the agency collects data through the CPMS/UPR data management system, but states that there is little evidence of the program overall using performance data to adjust program priorities, make resource allocations or take other management actions.</p>
<p>4. Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?</p>	<p>This question seems to relate more to the internal management of the Bureau of Health Professions than to the individual grantees.</p>
<p>5. Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?</p>	<p>This question seems to relate to functions within HRSA and the Bureau of Health Professions.</p>
<p>IV: Program Results</p>	
<p>1. Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?</p> <ul style="list-style-type: none"> • Increase the proportion of persons who have a specific source of reliable, continuing healthcare (96% by 2010). • Increase the proportion of health professionals completing funded programs that are serving in medically underserved communities (40% by 2010). • Increase the proportion of health professionals completing Health Professions funded programs who are underrepresented minorities and/or from disadvantaged backgrounds (50% by 2010) 	<p>The report notes that Health Professions programs need more than one year of data to show progress. It suggests that, while the first measure does not capture all of the specific activities of the program, “it is the most focused on final outcomes . . . and relates directly to the bulk of program efforts.”</p> <p>As noted earlier, the achievement of two of the three long-term goals are largely outside the scope of the Health Professions programs in general and AHEC in particular. It is unclear how these particular goals were formulated for the BHP programs.</p> <p>The current HRSA mission is to work to</p> <ul style="list-style-type: none"> • eliminate barriers to care • eliminate health disparities • assure quality of care • improve public health and health care systems

	<p>BHPr goals have been:</p> <ol style="list-style-type: none"> 1. To improve access to quality health care through appropriate preparation, composition and distribution of the health care workforce 2. To improve access to a diverse and culturally competent health professions workforce <p>The performance measures used to demonstrate progress need to be in alignment with the scope of the specific Health Professions programs.</p>
<p>2. Does the program (including program partners) achieve its annual performance goals?</p> <ul style="list-style-type: none"> • Increase the percentage of health professionals supported by the program training in underserved areas. (30% by 2004) • Increase the percentage of health professionals supported by the program who enter practice in underserved areas. (30% by 2004) • Increase the proportion of all health professionals completing Title VII and Title VIII funded Health Professions programs who are underrepresented minorities and/or from disadvantaged backgrounds. (40% by 2004) 	<p>The report rates performance on these criteria more positively. It notes that performance on related measures has exceeded goals in some areas (e.g., the number of students training in underserved areas and the number of minority/disadvantaged graduates and program completers). It also notes that performance has declined in some key goals, such as the number of graduates going into primary care.</p> <p>As opposed to the long-term outcome goals, the annual performance goals may be reasonably affected by the health professions programs. However, given the different approaches of the various programs subsumed under the BHPr, uniform annual performance goals may be difficult to formulate. It will also be important to build in some understanding of factors external to the programs that may depress performance in certain areas (change in affirmative action admissions policies and cuts in reimbursement rates for primary care physicians, for example).</p> <p>Understanding the antecedent conditions underlying the problems represented by these goals and targeting health professions programs to specifically address the antecedent conditions can produce a more appropriate set of performance measures for each program.</p>
<p>3. Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?</p>	<p>The negative evaluation here rests on a calculation of federal investment per placement in an underserved area, which has increased over the last three years. On the other hand, the total federal investment per clinician trained and per minority graduate has decreased. The report also notes that some institutions participating in the faculty loan repayment program waive matching requirements, thus reducing the impact per federal investment.</p> <p>The development of logic models and subsequent targeting of program activities to antecedent conditions can help identify opportunities for increased efficiency.</p>

<p>4. Does the performance of this program compare favorably to other programs with similar purpose and goals?</p>	<p>In comparison to Medicare Graduate Medical Education (GME) payments, the BHP programs provide more direction and its grant recipients are more likely than the national average to provide care in underserved areas and to be from a minority background.</p> <p>The National Health Service Corps, to which the health professions programs are compared, is a single program with a well-defined mission. In contrast, the health professions programs are a diverse group of 40 individual programs. In addition, the NHSC's long-term goals coincide more closely with NHSC programming than is the case for the long-term goals of the health professions programs.</p> <p>While the Health Professions programs do not directly place graduates into underserved settings, they do provide for the education of students in those settings and thus prepare students for practice in primary care in underserved settings to provide the NHSC with well-prepared, committed candidates, not just graduates who are looking for loan repayment options.</p>
<p>5. Do independent and quality evaluations of this program indicate that the program is effective and achieving results?</p>	<p>As noted previously, in assessing the Health Professions programs approximately 40 individual programs were lumped together. These programs were developed by Congress at different times and for different purposes and need to be evaluated according to the original purpose of the individual program, as well as current overall goals of the agency. OMB makes note of research indicating that the underlying premise of the Health Professions programs could work.</p>

Using logic models to identify better performance measures

The independent evaluative study of the AHEC program conducted by Ricketts, et al. recommended that program logics or logic models should form the foundation for improving effectiveness. Logic models, as the name suggests, are intended to logically link problems, strategies, and outcomes. The three-step process described below was developed as a unified approach to problem identification, strategic planning, and evaluation. This approach provides a means for avoiding "activity traps" by identifying root causes first, targeting programs appropriately, and demonstrating that program strategies actually work.

In applying a logic model approach, the organizational structure of the health professions programs must be considered. On the one hand, each individual program could develop its own logic model and make individual improvements, which will ultimately lead to an overall improved score. The problem is that when the responsibility is shifted peripherally, individual programs will each invest dollars to solve the same issue, and they will develop separate systems that cannot be integrated across programs. It would be more cost-effective to have the Bureau of Health Professions take the lead in coordinating logic model development so that each program is using the same approach, thereby ensuring that systems and data can be integrated.

Three Steps to Effectiveness - The three-step process described below is based on an article in the *American Journal of Evaluation* by Renger and Titcomb (2002). The PART is a tool to identify areas of deficiency. In a similar way, the approach described by Renger and Titcomb is a tool to help ensure that programs can explain what they are doing, why they are doing it, how they are doing it, and whether it works. This approach has been successfully employed in the Arizona AHEC and is now being considered by other state agencies and the CDC. It is a means for understanding the issues, coordinating partners, identifying potential gaps, identifying areas of redundancy, targeting services, and establishing meaningful outcomes.

Step 1. Identifying Antecedent Conditions - Most problems that are identified are actually symptoms. A shortage of health professionals in rural and underserved areas is a symptom of an underlying set of conditions. It is important to identify and make explicit the root causes or antecedent conditions of a problem. To be effective a program must target the root causes, not just the symptom itself.

The explicit identification of antecedent conditions helps to avoid the common tendency to jump straight from the identified problem to strategies. The result of this tendency is called an activity trap. Results from a recent pilot study can help illustrate how identifying antecedent conditions can avoid an activity trap. The pilot study, designed to understand the root causes of problems related to retention of health care professionals in rural areas, learned that professional isolation was a major reason why health care professionals do not stay in rural settings. The approach to addressing provider retention in rural areas had been the provision of straightforward, clinical CE/CME, which fails in and of itself to address the issue of professional isolation. Jumping straight from lack of provider retention to traditional CE/CME constitutes an activity trap. Knowing that professional isolation is a root cause of poor provider retention enabled a restructuring of CE/CME. In addition to providing opportunities for skill development, the content of CE/CME is also seen as a lure for bringing professionals in rural settings together. Participants are now exposed to strategies to reduce professional isolation, such as list-serves, discussion forums, and regular scheduled meetings after the CE/CME event. These opportunities for ongoing connection did not exist before. Participants came, got CME credit and left, which did little, if anything, to address issues related to professional isolation. With an understanding of the root cause of the problem strategies for addressing professional isolation were developed and implemented.

Before beginning an inquiry into the antecedent conditions the problem must be clearly defined. While there may be some overlap, a different set of conditions is germane to improving the supply of health professionals as compared to improving the minority representation as compared to affecting the distribution of health care providers. For the purpose of developing logic models, it is imperative that these problems be treated separately.

Once the problem has been clearly articulated, the focus shifts to identifying the antecedent conditions. The key to uncovering the antecedent conditions of any problem is to simply ask “why?” Experts, the public, and research evidence are used to create a visual map that depicts the problem of interest and its root causes. The importance of the visual map cannot be overstated. In addition to serving as a working memory, it clearly explains what conditions are of importance and why.

The health professions programs lend themselves to a tiered approach to developing logic models. The Bureau of Health Professions could work with individual programs to identify the first level of conditions contributing to the problem. For example, the CDC has identified lead poisoning in children as a significant problem. When asking why this problem persists long after lead has been removed from house paint, the first level of inquiry reveals conditions such as poorly maintained housing, contaminated drinking water, air pollution, and parents’ hobbies. Having identified the first level of conditions contributing to lead poisoning the CDC can work with its program partners (e.g., HUD, WIC, and the

EPA) to develop partner-specific logic models. These logic models would probe deeper into the root causes in each area. For example, why is lead paint still found in homes? (e.g., laws, delinquent landlords, persistence of lead paint in window sashes generating dust-borne lead particles in older homes), why is lead found in drinking water? (e.g., industry compliance problems) and so forth.

Step 2. Target Programs - With the visual map from Step 1 it becomes apparent that the problem(s) being addressed have numerous antecedent conditions. Hundreds of antecedent conditions may contribute to the problems of encouraging youth to pursue a health career, placing health professionals in a rural or underserved area, and retaining health professionals currently working in rural or underserved areas. Clearly, many of the antecedent conditions identified are beyond the control of AHEC. What is required is a set of decision criteria for identifying the antecedent conditions that a program can affect meaningfully. Examples of decision criteria being used by AHEC include whether (1) research evidence supports the linkage between the antecedent condition and the goal, (2) expertise resides within the AHEC to effect a change in the antecedent condition, (3) change can be expected within the timeframe of the funding cycle, (4) resources exist within the AHEC to implement and sustain the strategy, and (5) other programs are targeting the same antecedent conditions in the same way.

Armed with a clear understanding of the antecedent conditions for which it is responsible, health professions programs can then develop strategies. Throughout this process, programs must be able to explain how the proposed components of each strategy will affect the antecedent conditions. Central to this is a detailed documentation of each strategy, which is necessary for two important reasons. First, without a detailed description replication of the program is impossible. Second, strategy documentation guides program evaluation. Evaluators cannot assess programs if they do not know exactly how the program is supposed to be operating.

The visual map is a useful tool in the identification of redundancies and potential gaps in service. By simply color-coding the antecedent conditions targeted by each program it is easy to appreciate those antecedent conditions not being addressed (i.e., not colored) and those that are redundant (i.e., multiple colors). In this way, the logic model can help ensure fiscal responsibility.

Step 3. Measurement - The first level logic model would identify the overarching toward which all health professions programs are working. The responsibility of gathering and monitoring changes to the first tier goal should fall to the Bureau of Health Professions. In the CDC example provided above, the surveillance division is tracking the incidence of lead poisoning in children. Making each individual program responsible for collecting long-term outcomes has proven a difficult if not impossible task.

Annual or more immediate outcomes are derived directly from the antecedent conditions targeted by each individual program. Each program identifies outcomes for the targeted antecedent conditions over which it has control and can demonstrate change. Developing a common set of measures for identified antecedent conditions is important. The ability to compare the success of different approaches targeting the same antecedent condition depends on using the same measures. Although the Bureau of Health Professions should not direct the development of strategies by individual programs, it should help identify uniform indicators or measurement tools to be used to assess the antecedent conditions.

Summary

The logic model approach described above clarifies the relevant problems, identifies the antecedent conditions over which health professions programs have some degree of control, rationalizes program planning, and assists in developing meaningful outcome measures. In doing so, it addresses many of the deficiencies cited in the PART.

Coordinating the development of logic models through the Bureau of Health Professions will provide greater assurance that each program is targeting the antecedent conditions and that they are ultimately affecting change in the overarching goal. The net result of this process is that the concerns in Section 1 of the PART, Program Purpose and Design, will be addressed through a clear program purpose, which will, in turn, lead to coordinated activity that increases the likelihood of significantly impacting the problem. Further, the ability to coordinate programs using the logic model directly addresses the need for improved strategic planning as identified in Section II of the PART.

Requiring a detailed description of strategies gives evaluators the information they need to design annual outcome measures. Instituting such a monitoring system is central to meeting deficiencies in Section III of the PART, Program Management.

Shifting responsibility for collecting data on long-term outcomes to the Bureau of Health Professions, relating annual outcomes to those antecedent conditions over which each program has direct control, and providing a standard set of measures for assessing the antecedent conditions will address the severe shortcomings noted in Section IV of the PART, Program Results.

Less directly addressed is the need for an independent evaluation called for in Section IV of the PART. In addition to the improvements that will result from the three steps outlined above, a periodic third party evaluation remains critical to ensuring the integrity of all parties.

This response was authored by:

Ralph Renger, PhD
Arizona AHEC Program
520.318.7151 or renger@u.arizona.edu

Charles Huntington, MPH, PA
Connecticut AHEC Program
860.679.7968 or huntington@adp.uchc.edu